Notice

of

Rulemaking Hearing

Tennessee Department of Finance and Administration

Bureau of TennCare

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in Room 16 of the Legislative Plaza, 6th Avenue North, Nashville, Tennessee, at 9:00 a.m. C.S.T. on the 18th day of November 2002.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Finance and Administration, Bureau of TennCare, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings) to allow time for the Bureau of TennCare to determine how it may reasonably provide such aid or service. Initial contact may be made with the Bureau of TennCare's ADA Coordinator by mail at the Bureau of TennCare, 729 Church Street, Nashville, Tennessee 37247-6501 or by telephone at (615) 741-0155 or 1-800-342-3145.

For a copy of this notice of rulemaking hearing, contact George Woods at the Bureau of TennCare, 729 Church Street, Nashville, Tennessee 37247-6501 or call (615) 741-0145.

Substance of Proposed Rule

Rule Chapter 1200-13-1 General Rules is amended by deleting rule 1200-13-1-.17 in its entirety and replacing it with a new rule 1200-13-1-.17 which shall read as follows:

1200-13-1-.17 Statewide Home and Community Based Services Waiver for the Elderly and Disabled.

(1) Definitions. The following definitions shall apply for interpretation of this rule:

(a) Administrative Lead Agency - the approved agency or agencies with which the Bureau of TennCare contracts for the provision of covered services through the Statewide Home and Community Based Services Waiver for the Elderly and Disabled.

(b) Bureau of TennCare - the Bureau in the Tennessee Department of Finance and Administration which is responsible for administration of the Title XIX Medicaid program.

(c) Caretaker - one or more adult individuals who sign an agreement with the Administrative Lead Agency to provide services to the Enrollee as outlined in paragraphs (4) and (5) to

meet the needs of the Enrollee during the hours when Waiver Services are not being provided by the Administrative Lead Agency.

(d) Case Management - services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers shall be responsible for development of the plan of care and for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care.

(e) Case Management Team - a multi-disciplinary team of health care professionals that assesses an Enrollee's medical, functional, and social needs after enrollment in the Waiver and develops, monitors, and periodically updates a goal-oriented Individual Care Plan based on the Enrollee's needs. The multi-disciplinary team shall be composed of the Case Manager, a physician, a registered nurse, a social worker, and other appropriate health care professionals.

(f) Case Manager - a person who is responsible for screening potential applicants to determine if they meet the requirements for enrollment in the Waiver; overseeing the development, implementation, and monitoring of an Individual Care Plan based on the Enrollee's medical, functional, and social needs and the Safety Plan; coordinating the provision of Waiver Services and other services regardless of payment source, including securing appropriate service providers; and monitoring to assure that appropriate Waiver Services and other services are being provided; and documenting case management activities.

(g) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a PreAdmission Evaluation signifying that the individual requires services provided through the Statewide Home and Community Based Services Waiver for the Elderly and Disabled as an alternative to care in a Nursing Facility.

(h) Department - the Tennessee Department of Finance and Administration.

(i) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, delay, or reduction in amount, scope, and duration of a Waiver service or a refusal or failure to provide such service.

(j) Disenrollment - the voluntary or involuntary termination of enrollment of an individual receiving services through the Statewide Home and Community Based Services Waiver for the Elderly and Disabled.

(k) Enrollee - a Medicaid Eligible who is enrolled in the Statewide Home and Community Based Services Waiver for the Elderly and Disabled in Tennessee.

(l) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides in Tennessee, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities, and Homes for the Aged (Residential Homes for the Aged).

(m) Home and Community Based Services Statewide Waiver for the Elderly and Disabled - the Home and Community Based Services waiver project approved for Tennessee by the Centers For Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals who reside in Tennessee, who are aged or disabled, and who meet Medicaid's criteria for placement in a Nursing Facility.

(n) Home Delivered Meals - nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act, that provide at least one third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences - National Research Council) and that will be served in the Enrollee's home. Special diets shall be provided in accordance with the Individual Plan of Care when ordered by the Enrollee's physician.

(o) Homemaker Services - services consisting of general household activities and chores (e.g., sweeping, mopping, dusting, making the bed, washing dishes, personal laundry, ironing, mending, and meal preparation and/or education about the preparation of nutritious appetizing meals; assistance with maintenance of a safe environment; and errands essential to the Enrollee's care (e.g., grocery shopping, having prescriptions filled) provided by a trained homemaker when the enrollee is unable to perform such activities and when the individual regularly responsible for these activities is unable to perform such activities for the Enrollee.

(p) Individual Plan of Care - an individualized written plan of care which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees and which meets the requirements of paragraph (8) herein.

(q) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have TennCare make reimbursement for covered services.

(r) Minor Home Modifications - the provision and installation of certain home mobility aides (e.g., ramps, rails, non-skid surfacing, grab bars, and other devices and minor home modifications which facilitate mobility) and modifications to the home environment to enhance safety. Excluded are those adaptations or improvements to the home which are of general utility and which are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

(s) Nursing Facility - a Medicaid-certified nursing facility approved by the Department.

(t) Personal Care Services - services provided to assist the Enrollee with activities of daily living, and related essential household tasks (e.g. making the bed, washing soiled linens

or bedclothes that require immediate attention), and other activities that enable the Enrollee to remain in the home, as an alternative to Nursing Facility care, including the following:

1. Assistance with activities of daily living (e.g., bathing, grooming, personal hygiene, toileting, feeding, dressing, ambulation);

2. Assistance with cleaning that is an integral part of personal care and is essential to the health and welfare of the Enrollee;

3. Assistance with maintenance of a safe environment.

(u) Personal Emergency Response Systems (PERS) - is an electronic devices which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

(v) "Plain language" - any notice or explanation that requires no more than a sixth grade level of education as measured by the Flesch Index, Fog Index, or Flesch-Kincaid Index.

(w) PreAdmission Evaluation (PAE) - a process of assessment approved by the Bureau of TennCare and used to document an individual's current medical condition and eligibility for care in a Nursing Facility.

(x) PreAdmission Screening/Annual Resident Review (PASARR) - the process by which the State determines whether an individual who resides in or seeks admission to a Medicaid-certified Nursing Facility has, or is suspected of having, mental illness or mental retardation, and, if so, whether the individual requires specialized services.

(y) Recertification - the process approved by the Bureau of TennCare by which the Enrollee's physician assesses the medical necessity of continuation of Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.

(z) Respite Care - services provided to individuals unable to care for themselves when there is an absence or need for relief of those persons normally providing the care. Respite services will be furnished on a short-term basis in a nursing facility or assisted care living facility, not to exceed nine (9) days per waiver year. The intent of Respite is to provide short-term relief for caregiver vacations and emergency situations that may involve the temporary loss of a caregiver (e.g. hospitalization, illness of another relative).

(aa) Safety Plan - an individualized plan by which the Administrative Lead Agency ensures the health, safety, and welfare of Enrollees who do not have 24-hour caretaker services and which meets the requirements of (5)(c)4.

(bb) Screening - the process by which the Administrative Lead Agency determines that an applicant meets the requirements for enrollment in the Home and Community Based Services Statewide Waiver for the Elderly and Disabled. The screening process shall include verifying whether an individual is Medicaid eligible in Tennessee; whether an individual is eligible for care in a Nursing Facility; whether an individual with an approved PreAdmission Evaluation is eligible for Waiver Services; whether the individual's medical, functional, and social needs can be met through the Waiver; and whether there is a caretaker available.

(cc) Subcontractor - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Administrative Lead Agency to provide Waiver Services to an Enrollee.

(dd) Urgent care - medical assistance services which the Enrollee or the Enrollee's representative and the primary care provider or treating specialist have attested are required promptly to prevent substantial deterioration of the individual's health status and the failure to provide such services promptly is likely to cause substantial harm.

(ee) Waiver - the Home and Community Based Services Statewide Waiver for the Elderly and Disabled as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.

(ff) Waiver Eligible - a Medicaid eligible resident of Tennessee who has a PreAdmission Evaluation that has been approved by the Bureau of TennCare for nursing facility level of care.

(gg) Waiver Services - covered services provided through the Statewide Home and Community Based Services Waiver for the Elderly and Disabled as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.

(2) Waiver Services. Covered Waiver Services shall include the following:

(a) Case Management. All case management contacts shall be documented in the Enrollee's medical record and shall include one face-to-face visit per month, by a registered nurse or a social worker, with the Enrollee in the Enrollee's home. At least every 90 days, the home visit shall be made by a registered nurse unless otherwise directed in the waiver. Such monthly documentation shall note that the Individual Plan of Care has been reviewed and revised as appropriate.

(b) Home-delivered Meals.

1. The Administrative Lead Agency shall ensure that providers of home meals are properly licensed or certified by the appropriate regulatory authority and shall require that such providers comply with all laws, ordinances, and codes regarding preparation, handling, and delivery of food.

2. For those Enrollees who require medically prescribed diets, the Administrative Lead Agency shall ensure that such meals are planned by a registered dietitian who provides consultation to the licensed nurse supervising the Enrollee's care.

(c) Minor Home Modifications.

1. Minor home modifications shall not be provided unless specified in the Individual Plan of Care. The Administrative Lead Agency shall notify the Bureau of TennCare and obtain prior authorization for minor home modifications exceeding $1,200 prior to initiating the intended modification.

2. The Bureau of Tenncare shall be the payor of last resort for minor home modifications.

(d) Personal Care Services.

1. Personal care aides shall meet the standards of education and training required by the Administrative Lead Agency and approved by the Bureau of TennCare. Enrollees with a diagnosis of mental retardation can only receive personal care services from a licensed home health agency or an agency licensed by the Department of Mental Health and Developmental Disabilities.

2. The personal care aide shall report to the Case Manager any significant changes in the Enrollee's physical or mental status.

(e) Personal Emergency Response Systems. Personal Emergency Response Systems shall be provided, as specified in the Individual Plan of Care and Safety Plan, for Enrollees:

1. Who receive daily caretaker services but who are alone for significant parts of the day and who would otherwise require extensive routine supervision; and

2. Who, based on an assessment by the Administrative Lead Agency of the Enrollee's mental and physical capabilities, have the capability to effectively utilize such a system.

(f) Homemaker Services. Homemakers shall meet state standards for education and training.

(g) Respite Services.

1. Respite care providers must have a good knowledge of basic living skills and knowledge of Basic English, sufficient to write reports, keep records and read instructions.

2. The Administrative Lead Agency shall ensure that providers have the ability to provide residential care, and the ability to prepare required routine written records and reports.

(3) Documentation of Waiver Services.

(a) The Administrative Lead Agency shall ensure that all services are accurately and timely documented.

(b) Documentation of Waiver services must adequately demonstrate that services are provided in accordance with the individual plan of care and the approved waiver service definitions.

(4) Notification. Upon approval of a PreAdmission Evaluation for Nursing Facility care for an individual residing in Tennessee, the Department shall provide the individual with the following:

(a) A simple explanation of the Waiver and Waiver Services;

(b) Notice of the opportunity to apply for enrollment in the Waiver and an explanation of the enrollment process; and

(c) A statement that participation in the waiver program is voluntary.

(5) Enrollment.

(a) When an individual is determined to be likely to require the level of care provided by a Nursing Facility, the Administrative Lead Agency shall inform the individual or the individual's legal representative of all feasible alternatives available under the waiver and shall offer the choice of either Nursing Facility or Waiver Services.

(b) Enrollment in the Waiver shall be voluntary and open to all Waiver Eligibles who reside in Tennessee, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee. Enrollment may also be restricted if sufficient funds are not appropriated by the legislature to support full enrollment.

(c) To be eligible for enrollment, an individual must meet all of the following criteria:

1. The individual must be Medicaid Eligible, must meet the Nursing Facility eligibility criteria specified in TennCare Rule 1200-13-1-.10, and must have a PreAdmission Evaluation approved by the Bureau of TennCare.

(i) The PreAdmission Evaluation shall include the physician's initial plan of care which includes, but is not limited to, diagnoses and any orders for medications, diet, activities, treatments, therapies, restorative and rehabilitative services, or other physician-ordered services needed by the Enrollee.

(ii) The individual's physician must certify on the PreAdmission Evaluation that the individual requires Waiver Services.

2. The individual's medical, functional, and social needs must be such that they can be effectively and safely met through the Waiver, as determined by the Administrative Lead Agency based on a pre-enrollment screening.

3. An individual shall have one or more caretakers, as specified in (6)(a), designated to provide caretaker services each day in the Enrollee's home and, as needed, in other locations to ensure the health, safety, and welfare of the Enrollee. An individual shall have 24-hour caretaker services unless it is determined by an assessment that the needs of the individual can be met, and that the health, safety, and welfare of the individual can be assured, through the provision of daily (but less than 24-hour) caretaker services and through provision of a Personal Emergency Response System. Documentation of such assessment shall be included in an individualized Safety Plan that is developed, reviewed, and updated by the Administrative Lead Agency. If it is so determined that the health, safety, and welfare of the individual can be assured without 24-hour caretaker services, the individual shall have caretaker services provided for some portion of the day each day.

4. An individual who does not have 24-hour caretaker services shall have an individualized Safety Plan that is based on an assessment of the individual's medical, functional, and social needs and capabilities and that is approved, monitored, and updated as needed, but no less frequently than annually, by the Administrative Lead Agency. The Safety Plan shall describe:

(i) The medical, functional, and social needs and capabilities of the individual and how such can be met without jeopardizing the health, safety, and welfare of the individual;

(ii) The type and schedule of caretaker services to be provided each day, specifying hours per day and days per week;

(iii) Other support services provided to the Enrollee;

(iv) Personal Emergency Response Systems (if utilized) which are designed to enable Enrollees, who meet the requirements of (2)(e), to secure help in an emergency; and

(v) Other services, devices, and supports that ensure the health, safety, and welfare of the Enrollee.

5. All homes must provide an environment adequate to reasonably ensure the health, safety, and welfare of the Enrollee.

(d) An individual who is capable of living alone or independently shall not be eligible for enrollment or continued enrollment in the Waiver.

(e) Enrollment of new Enrollees into the Waiver may be suspended when the average per capita fiscal year expenditure under the Waiver exceeds or is reasonably anticipated to exceed 100% of the average per capita expenditure that would have been made in the fiscal year if the care was provided in a Nursing Facility.

(6) Caretaker.

(a) Caretaker services shall be provided by one or more adult individuals, aged 18 or older, who sign an agreement with the Administrative Lead Agency to provide the following services to the Enrollee, as well as any additional services outlined in the Individual Plan of Care and the Safety Plan, to meet the needs of the Enrollee during the hours when Waiver Services are not being provided by the Administrative Lead Agency:

1. Assistance with grooming, bathing, feeding, and dressing;
2. Assistance with medications that are ordinarily self-administered;
3. Assistance with ambulation as needed;
4. Household services essential to health care and maintenance in the home;
5. Meal preparation; and
6. Any other assistance necessary to support the Enrollee's activities of daily living.

(b) One or more caretakers shall be available full time or part time each day in the Enrollee's home, as determined appropriate by the Administrative Lead Agency and as specified in the Individual Plan of Care and the Safety Plan, to provide care to the Enrollee. Enrollees who do not have a 24-hour caretaker shall have a Personal Emergency Response System or equivalent mechanism for ensuring emergency assistance and shall be mentally and physically capable of using it based on an assessment by the Administrative Lead Agency.

(7) PreAdmission Evaluations, Transfer Forms, and PASARR Assessments.

(a) A PreAdmission Evaluation is required when a Medicaid Eligible is admitted to the Waiver.

(b) A Transfer Form is required in the following circumstances:

1. When an Enrollee having an approved unexpired PreAdmission Evaluation transfers from the Waiver to Level 1 care in a Nursing Facility.

2. When a Waiver Eligible with an approved unexpired PreAdmission Evaluation transfers from a Nursing Facility to the Waiver.

(c) A Level I PASARR assessment for mental illness and mental retardation is required when an Enrollee with an approved, unexpired PreAdmission Evaluation transfers from the Waiver to a Nursing Facility. A level II PASARR evaluation is required if a history of mental illness or mental retardation is indicated by the Level I PASARR assessment, unless criteria for exception are met.

(d) An Administrative Lead Agency that enrolls an individual without an approved PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Administrative Lead Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement. If an Administrative Lead Agency enrolls a Medicaid Eligible without an approved PreAdmission Evaluation, the individual must be informed by the Administrative Lead Agency that Medicaid reimbursement will not be paid until and unless the PreAdmission Evaluation is approved.

(e) The Administrative Lead Agency shall maintain in its files the original PreAdmission Evaluation and, where applicable, the original Transfer Form.

(f) An updated Safety Plan for Enrollees who do not have 24-hour caretaker services shall be required as an attachment to the PreAdmission Evaluation or Transfer Form.

(8) Individual Plan of Care.

(a) The Individual Plan of Care shall be an individualized written plan of care that specifies the services designed to meet the medical, functional, and social needs of the Enrollee and that includes, but is not limited to, the following Enrollee information:

1. Diagnoses;

2. A description of Waiver Services and any other services regardless of payment source, including caretaker services, that the Enrollee requires to reside in the community as an alternative to care in a Nursing Facility, including the amount, frequency (number of days per week), and duration (specific number of hours per day rather than a range of hours) of services and the type of provider to furnish each service;

3. Outcome objectives;

4. Any treatments, therapies, activities, social services, rehabilitative services, nursing related services, home health aide services, specialized equipment, medications (including dosage, frequency, and route of administration), diet, and other services needed by the Enrollee;

5. The names of each caretaker and each caretaker's schedule, including the frequency (number of days per week) and duration (hours per day) of caretaker services; and

6. A Safety Plan for Enrollees who do not have 24-hour caretaker services.

(b) Within thirty (30) working days after enrollment, the Case Management Team shall review the Physician's Plan of Care and shall develop the Individual Plan of Care. Within five (5) working days of completion of the Individual Plan of Care, the Administrative Lead Agency shall review and approve the Individual Plan of Care.

(c) The Individual Plan of Care shall be periodically reviewed to ensure that the Waiver Services furnished are consistent with the nature and severity of the Enrollee's disability and to determine the appropriateness and adequacy of care and achievement of outcome objectives outlined in the Individual Plan of Care. The minimum schedule for reviews shall be as follows:

1. The Individual Plan of Care shall be reviewed by a registered nurse or Social Worker Case Manager as needed, but no less frequently than every thirty (30) calendar days.

2. The Individual Plan of Care shall be reviewed and signed by the Case Management Team as needed, but no less frequently than annually. The attending physician is not required to sign the Individual Plan of Care if current signed physician orders are included with the Individual Plan of Care.

(d) Waiver Services shall be provided in accordance with the Enrollee's Individual Plan of Care.

(9) Physician Services.

(a) The Enrollees's attending physician or other licensed physician shall write new orders for the Enrollee as needed, and, at a minimum, every ninety (90) calendar days.

(b) The Administrative Lead Agency shall ensure that each Enrollee receives physician services as needed, and, at a minimum, an annual medical examination or physician visit, and shall document such in the Enrollee's record.

(10) Reevaluation and Recertification of Need for Continued Stay.

(a) The Administrative Lead Agency shall perform reevaluations of the Enrollee's need for continued stay in the Waiver within 365 calendar days of the date of enrollment and at least annually thereafter.

(b) Recertifications, documented in a format approved by the Bureau of TennCare, shall be performed by the Enrollee's physician within 365 calendar days of the initial certification date and at least annually thereafter. The Administrative Lead Agency shall maintain in its files a copy of the recertification of need for continued stay.

(11) Voluntary Disenrollment.

(a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's legal representative to the Administrative Lead Agency. Prior to disenrollment, the Administrative Lead Agency shall assist the Enrollee in locating alternate services to provide the appropriate level of care and shall assist in transitioning the enrollee to the new services.

(b) If the Enrollee's medical condition or social environment deteriorates such that the medical, functional, and social needs cannot be met by the Waiver, the Enrollee or the Enrollee's legal representative may request disenrollment from the Waiver. The Administrative Lead Agency shall assist the individual with arranging placement in a nursing facility as appropriate.

(c) Upon voluntary disenrollment from the Waiver, the individual shall be entitled to receive Medicaid covered services only if still eligible for Medicaid.

(12) Involuntary Disenrollment.

(a) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:

1. The Statewide Home and Community Based Services Waiver for the Elderly and Disabled is terminated.

2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.

3. An Enrollee is no longer a resident of Tennessee or remains outside the State for a period exceeding 90 days, excluding extended out-of state stays for college education or enrollee medical emergency.

4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.

5. The condition of the Enrollee deteriorates such that the medical, functional, and social needs of the Enrollee cannot be met by the Waiver.

6. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.

7. The Enrollee no longer has a caretaker, as defined herein, or the caretaker is unwilling or unable to provide services needed by the Enrollee, and an alternate caretaker cannot be arranged.

8. The Enrollee or the Enrollee's caretaker refuses to abide by the Individual Plan of Care, the Physician's initial plan of care, or related Waiver policies, resulting in the inability of the Waiver to assure quality care.

9. The health, safety, and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan or an approved Individual Plan of Care, or the continuing need for Waiver Services is not recertified by the Enrollee's physician.

(b) If the individual is involuntarily disenrolled from the Waiver, the Administrative Lead Agency shall assist the Enrollee in locating a Nursing Facility or other alternative providing the appropriate level of care. The Administrative Lead Agency shall assist in transferring and/or transitioning the Enrollee to such facility or other alternative.

(c) The Administrative Lead Agency shall notify the Bureau of TennCare in writing a minimum of 2 working days prior to issuing involuntary disenrollment notice to an Enrollee.

(d) Waiver Services shall continue until the date of discharge of the Enrollee from the Waiver.

(13) Reduction of Services.

(a) If the Enrollee's condition substantially improves, the Administrative Lead Agency and the Bureau of TennCare shall have the right to reduce Waiver Services.

(b) Enrollees shall be provided written notice, including an explanation of the right to appeal and instructions for submitting an appeal for any reduction in Waiver Services.

(c) The Administrative Lead Agency must use approved notice formats or develop appropriate notice formats. If notice formats are developed, notice templates must be submitted to TennCare for review and approval prior to use.

(14) Administration of Services. The Administrative Lead Agency shall ensure the delivery of Waiver Services to Enrollees and shall ensure that related activities including, but not limited to, the following are performed:

(a) Pre-enrollment screening of individuals, including assessment of the individual's medical, functional, and social capabilities and needs; appropriateness for placement in the Waiver; and the ability of the caretaker to adequately care for the Enrollee in the home setting;

(b) Annual reevaluations of the Enrollee's need for continued stay in the Waiver;

(c) Enrollment of Waiver Eligibles into the Waiver after screening;

(d) Development, implementation, and monitoring of the Individual Plan of Care, including the Safety Plan if a Safety Plan is required;

(e) Coordinating and monitoring the total range of services for Enrollees, regardless of payment source;

(f) Initial certification by the Enrollee's physician of the Enrollee's need for care in a Nursing Facility and annual recertification of the medical necessity of the continuation of Waiver Services for the Enrollee;

(g) Supervision of support service staff;

(h) Ongoing monitoring of Enrollee and family situations and needs;

(i) Maintenance of comprehensive medical records and documentation of services provided to Enrollees;

(j) Expenditure and revenue reporting in accordance with state and federal requirements;

(k) Any marketing activities performed for the purpose of providing information about the program to potential Enrollees;

(l) Assurance of quality and accessible Waiver services which are provided in accordance with State and Federal Waiver rules, regulations, policies and definitions;

(m) Contacts with Enrollees, caretakers, and service providers in accordance with state and federal requirements;

(n) Assurance that each Enrollee has appropriate caretaker services provided each day in the Enrollee's home by one or more competent adult individuals who sign an agreement with the Administrative Lead Agency;

(o) Assurance of the safety of the Enrollee through appropriate caretaker services, supervision, and other services and supports, as described in the Individual Plan of Care and the Safety Plan;

(p) Implementation of a grievance/appeals process approved by the Bureau of TennCare;

(q) Provision of expert testimony by appropriate professionals during contested case hearings; and

(r) Compliance with all applicable rules of the Tennessee Medicaid Program.

(15) Reimbursement of Administrative Lead Agency and Subcontractors.

(a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care was provided in a Nursing Facility. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in a Nursing Facility.

(b) The provider of Waiver Services shall be reimbursed based on a rate per unit of service.

(c) The Administrative Lead Agency shall ensure that a diligent effort is made to collect patient liability if it applies to the Enrollee in accordance with 42 CFR § 435.726. The Administrative Lead Agency shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Administrative Lead Agency and to the Bureau of TennCare's fiscal agent, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.

(d) The Provider of waiver services shall submit bills for services to the Bureau of TennCare's fiscal agent using a claim form approved by the Bureau of TennCare. On the claim forms, the waiver service provider shall use a provider number assigned by the Bureau of TennCare.

(e) Reimbursement shall not be made to the provider of Waiver Services on behalf of Enrollees for therapeutic leave or fifteen-day hospital leave normally available to Nursing Facility patients pursuant to rule 1200-13-1-.06 (4).

(f) Medicaid covered services other than those specified in the Waiver's scope of services shall be reimbursed by the Bureau of TennCare as otherwise provided for by federal and state rules and regulations.

(g) The Administrative Lead Agency shall ensure that the physician's initial certification and subsequent recertifications are obtained. Failure to perform recertifications in a timely manner and in the format approved by the Bureau of TennCare shall require a corrective action plan and shall result in full or partial recoupment of all amounts paid by the Bureau of TennCare during the time that recertification has lapsed.

(16) Subcontractors.

(a) The Administrative Lead Agency shall ensure that:

1. Services are provided by subcontractors who have signed contracts with the Administrative Lead Agency;

2. Subcontractors comply with the Quality Assurance Guidelines and other state and federal standards, rules, and regulations affecting the provision of Waiver Services;

3. Subcontractors carry appropriate professional liability insurance and other insurance (e.g., auto insurance if Enrollees are being transported); and

(b) Contracts between the Administrative Lead Agency and subcontractors for the provision of Waiver Services must be approved in writing by the Bureau of TennCare.

(17) Grievance Process. The Administrative Lead Agency shall provide a grievance process for Enrollees to contest any denial, termination, suspension or reduction of Waiver Services. The

grievance process is set forth in TennCare rule 1200-13-12-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits.

Statutory Authority: T.C.A. 4-5-202, 4-5-203, 71-5-105, 71-5-109, Executive Order No. 23.

D1012249

I certify that this is an accurate complete representation of the intent and scope of rulemaking proposed by the Tennessee Department of Finance and Administration.

_____
Manny Martins
Deputy Commissioner
Tennessee Department of Finance and Administration

Subscribed and sworn to me this the _____ day of _____, _____.

_____
Notary Public

My Commission Expires on the _____ day of _____, _____.

The notice of rulemaking set out herein was properly filed in the Department of State on the _____ day of _____, _____.

_____
Riley C. Darnell
Secretary of State

BY: _____

GW/D1012249